Linda Cole
Chief, Long Term Care Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Request for Informal Public Comment on COMAR 10.24.08 State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services.

Dear Ms. Cole:

Holy Cross Home Care and Hospice is pleased to have the opportunity to comment on the above document in reference to HOME HEALTH AGENCY.

Methodology
Although the Commission is commended for understanding that there is flexibility for agencies to absorb additional clients than currently being seen, the historically recognized docking rule stipulating that projected net need at or below 400 clients within a jurisdiction is assumed to be able to be absorbed by existing home health agencies is much too low to be applied on a statewide basis. In Montgomery County, where there already are 17 home health agencies, that would be an additional 23.5 clients per agency on average or three percent growth. In Prince George's County where there are 16 home health agencies it would mean an additional 25 clients per agency on average or four percent growth. . In reality home health agencies can easily flex those numbers. Table 2.1 demonstrates this. In 2002, there were fewer agencies (50 vs. 51) but they were able to serve eleven percent more patients (l03,921 vs. 93,462). The table shows that since 2002 there have been essentially the same number of home health agencies in the state. Those 50 Home Health agencies were able to do 103,921 admissions in 2002 but 51 agencies did only 93,462 in 2004. The decrease was most likely do to staffing problems. We suggest that a more realistic number would allow for at least a15% growth.

The scenario used in this document for forecasting Home Health Agency Need has been modified from the one used in the past. We agree that nursing home discharges should be considered. However, data presented by MHCC in a background paper dated April 27, 2006, on a graph on page 8 demonstrate that the percentage of discharges actually

have been 52-53% over the past several years and therefore the percent used for projecting should be closer to 50% not 60%. We strongly recommend using Scenario 1 assumptions therefore. There is nothing in the market place in the time frame projected that would lead one to believe that the percentage of nursing home discharges will increase above what they have been in the last several years.

Policy Issues

Policy 5.1 sets a minimum number of 3 home health agencies per jurisdiction even though the proposed (more robust) need projection methodology show no need for additional programs in the three Maryland counties with two home health agencies. The rationale for this is greater consumer choice. Although greater choice in some sectors of the economy may lead to better choices (higher quality, less cost) this is not the case for home health agencies. Because of chronic staffing shortages for both nurses and physical and occupational therapist across the state staffing costs go up as more agencies are forced to compete for a very limited resource. All that does is increase the cost to provide the service across the system. It does nothing to reduce costs or improve the quality of care being provided. In fact, CMS data presented to the MHCC during one of the working group sessions over the summer demonstrated **that Maryland Agencies do significantly better than the US average on nine of 11 outcome indicators monitored by CMS from the OASIS data set. The Commission should be doing everything in its power to support those agencies** and not undermine their ability to provide this quality of care. It is no small accomplishment.

Policy 5.3 sets a separate process outside of the need methodology for special populations not typically or readily served by home health agencies. Although there may be s small number of populations where this policy could potentially be useful, putting in the policy statement "a population group limited by the nature of its diagnosis or medical condition" OR by residing in "a specific continuing care retirement community" does not meet the criteria for "a special population not typically or readily served by home health agencies". These groups are already being served. These populations are included in the need methodology numbers. Allowing additional agencies for these populations eats away at the whole purpose and effectiveness of CON. Many home health agencies are now providing disease management programs and more will in the future. CCRC's by their nature "skim off" an elderly, more affluent population from the potential clients served by home health agencies making it more difficult for those agencies to provide charity care. The number of CCRC's will likely increase in the future. This policy therefore will lead to a decrease in the ability of existing agencies to provide the high quality cost effective care they now provide. It will do nothing to help the disadvantaged and under served populations in the State that are being served by the current agencies. If the Commission intends to set up a separate process to bypass the need methodology, it is critical that the review of such applications critically evaluate need, quality, the availability of charity care and the impact on other providers.

Policy 7.0 The growth of RSA's and NRSA's in the State is of concern as outlined by the Commission and we support efforts of the Commission to work with the Maryland Office of Health Care Quality and the Board of Nursing to find the best ways to address these issues.

Policy 7.1 The Commission has studied this issue several times in the past. The last time was over the summer of 2006. The final decision was to retain CON for Home Health. The CON process has provided a sound framework that supports the demonstrated quality that home health agencies provide in the State. CON has allowed reasonable competition in the marketplace where the market is large enough. It has served Marylanders well. It serves no purpose to continually study this issue. It is time for the Commission to move on to more substantive issues. We suggest that the Commission does not need to restudy this issue again unless there is a compelling case that justifies the need and expense.

Thank you for the opportunity to comment.

Sincerely,

Margaret Hadley, RN, MSN
Director
Holy Cross Home Care and Hospice